MANAGED HEALTH CARE IMPROVEMENT TASK FORCE
OCTOBER 28, 1997 REGULAR BUSINESS MEETING MINUTES

Adopted by the Task Force on December 12, 1997

Tuesday, October 28, 1997 -- 9:00am
1201 K Street, California Room
California Chamber of Commerce
Sacramento, California

I. CALL TO ORDER [Chairman Alain Enthoven, Ph.D.] - 9:15 AM

The sixth business meeting of the Managed Health Care Improvement Task Force [Task Force] was called to order by the Chairman, Dr. Alain Enthoven, at the California Chamber of Commerce in Sacramento, California.

II. ROLL CALL AND DECLARATION OF A QUORUM - [9:15 AM]

The following Task Force members were present: Dr. Bernard Alpert, Dr. Rodney Armstead, Dr. Donna Conom, Dr. Alain Enthoven, Ms. Nancy Farber, Ms. Jeanne Finberg, Hon. Martin Gallegos, Ms. Diane Griffiths, Mr. Bill Hauck, Mr. Mark Hiepler, Dr. Michael Karpf, Mr. Clark Kerr, Mr. Peter Lee, Dr. J.D. Northway, Ms. Maryann O'Sullivan, Mr. John Perez, Mr. John Ramey, Mr. Anthony Rodgers, Ms. Ellen Severoni, Dr. Bruce Spurlock, Mr. Ronald Willams, Mr. Allan Zaremberg, and Mr. Steve Zatkin.

The following Ex-Officio Members were also present: Ms. Kim Belshé, Ms. Marjorie Berte, Mr. Michael Shapiro, and Dr. David Wedegar.

III. OPENING REMARKS [Chairman Enthoven] – 9:19 AM

Chairman Enthoven began the meeting by stating that the procedures by which members will vote to adopt various components of the final report would be included on the November 21 meeting agenda for discussion. He also told members that the President's Commission on managed care has released its preliminary recommendations and that they are available on the Commission's web page.

He next introduced Assemblywoman Helen Thomson who requested an opportunity to address the Task Force on mental health issues as they relate to managed care. She discussed the issue of the State taking the necessary steps to correct discrimination against mental health patients and the enormous cost of mental health care. [The Assemblywoman introduced AB 1100 last session addressing this issue]. The Assemblywoman noted that there is a $28.8 billion cost to United States employers due to mental illness of some employees. She suggested that the movement be to eliminate the capitation of dollars spent on visits and treatment. Assemblywoman Thomson next introduced Dr. Goldman.

Dr. Goldman said that he hoped the Task Force would address the fact that many Californians are suffering from some form of mental illness and propose recommendations on the treatment of mental health and the cost thereof. He indicated that pursuant to a study he conducted, if employers paid an additional $1 in managed care benefits to cover mental health services, employees could have managed mental health care with unlimited access.

A. Executive Director's Report [Phil Romero, Ph. D.] – 9:34 AM

Executive Director Phil Romero said that he planned to discuss the Expert Resource Group papers and the report completion process, but felt that due to the complexity and time constraints of today's agenda, he would defer this discussion.

IV. CONSENT CALENDAR – 9:36 AM

Chairman Enthoven introduced the consent calendar, which was composed of one item - the proposed October 10, 1997 Business Meeting minutes. Dr. Spurlock moved to adopt the Consent Calendar and Ms. Severoni seconded the motion. The motion was unanimously adopted.

V. OLD BUSINESS – 9:37 AM

Before moving to old business, Chairman Enthoven clarified that members would be asked to vote on AB 2343 [Chapter 815, Statutes of 1996] mandated papers in their entirety while members would be asked to vote only on the Executive Summaries of non-mandated papers. Several members asked questions of the Chairman regarding which documents would be included in the final report. The Chairman indicated that the main portion of the report would contain all adopted papers/executive summaries and that all non-adopted background papers would be included as part of the report appendices.

In response to a question posed by Ms. Farber, Chairman Enthoven stated that there is not sufficient staff or staff time to devote to the production of minority reports.

Recognizing that papers undergo several versions before they are scheduled for Task Force adoption, Dr. Karpf requested that all subsequent changes to papers be indicated in "redline" text to ease their identification. Chairman Enthoven agreed and stated that this would be the method used from this point forward.

Ms. Farber requested that a roll call vote be taken on each paper/executive summary. After some discussion, Ms. Alice Singh, Deputy Director for Legislation and Operations, indicated that pursuant to the Task Force Bylaws and Rules, and Robert's Rules of Order, roll call votes would be allowed when requested, and must be requested after votes on an individual item have been cast [a.k.a. Division].

A. Discussion/Adoption of the Health Industry Profile ERG paper – 10:12 AM

Chairman Enthoven opened the floor for discussion of the Health Industry Profile paper. Dr. Werdegar began the discussion by asking for a full and fair description of the differences between for-profit and not-for-profit organizations. Ms. Griffiths stated that the for-profit/not-for-profit discussion in the paper contained gratuitous criticisms of physicians. She felt the paper should be more balanced, including a discussion of who profits from the current system. Mr. Shapiro was also concerned with the paper's characterization of research results comparing outcomes in for-profit and not-for-profit settings.

Mr. Lee made the suggestion to shelve voting of this paper given that he had only recently received several suggested changes from the California Medical Association (CMA) and that half of the Health Industry Profile paper had arrived late. Chairman Enthoven agreed. Both the Chairman and the Executive Director urged the members to submit suggested changes in writing to staff.

Mr. Zaremberg raised the point that the Health Industry Profile paper does not cover all of the topics listed in section (3)b(1) of AB 2343. Dr. Romero clarified that the papers under Task Force consideration do not each cover one topic in the legislation, but that collectively all of the topics are covered. Mr. Hauck suggested that the staff identify which papers cover which points of the legislation.

Ms. Severoni felt that consumer concerns, which compelled the Governor and Legislature to create the Task Force, were not adequately addressed. She requested that a discussion of the results from the Task Force's public survey and concerns raised during public testimony be included. Dr. Enthoven suggested that these issues be discussed in the paper about the impact of managed care on access, quality and cost. Dr. Romero suggested that this discussion be reserved for a more important location such as the Executive Summary.

Mr. Lee suggested that the descriptive sections from the Balancing Public and Private Sector Roles paper be moved into the Health Industry Profile paper.

Dr. Spurlock requested that the paper include more discussion of changes in the hospital industry. Ms. Farber had some concerns about using data about licensed beds rather than operational beds. She felt that data about licensed beds does not accurately reflect hospital capacity and suggested that the Department of Health Services determine how many hospital beds are actually operational. She also raised the point that the reduction of bed utilization may be due to the growing number of uninsured rather than the impact of managed care. Ms. O'Sullivan asked for more information about geographic variation in hospital bed supply, including different types of hospital beds.

Dr. Karpf requested that a discussion of the medical loss ratio be included in the paper. Chairman Enthoven stated that those figures are very hard to interpret. Dr. Romero suggested that the Task Force make a recommendation to standardize the accounting framework used to calculate the medical loss ratio.

Ms. O'Sullivan suggested that language be included stating that the consumers have no formal voice in plan decision making. She also suggested that the section regarding health industry integration be more balanced. She questioned whether the primary problems facing the health system could actually be met through integration and whether the industry was actually doing all of the things listed. She requested that there be qualifying language to the effect that the descriptions apply to the health care delivery system operating at its best.

Ms. Farber asked that the members recommend standardizing accounting with respect to the medical loss ratio, as the government did for the hospital industry. Dr. Karpf concurred with this suggestion.

Dr. Alpert moved that voting on the Health Industry Profile paper be deferred until the November 21 meeting. Mr. Kerr seconded the motion and it was unanimously adopted. The Chairman then encouraged members to forward any additional comments on the paper ASAP so that they could be included before the paper would be adopted.

Public Comment: – 11:00 AM

1. **Carol Lee** - California Medical Association. Ms. Lee expressed concern about a market bias in the paper. She suggested that there be a discussion in the paper of the problems with managed care, just as was done with the fee-for-service system. She also pointed out that AB 2343 does not call for a historical analysis of the industry, so perhaps that analysis should be left out of the paper.

2. **Beth Capell**- California Physicians Alliance. Ms. Capell asked that the members be aware of the important role medical groups have assumed in terms of managing risk.

3. **Catherine Dodd** - American Nurses Association of California. Ms. Dodd asked that the term "doctor" be replaced with the term "provider", which includes clinics, physicians, nurse practitioners, etc.

B. Discussion/Adoption of the Risk Adjustment Executive Summary - 11:16 AM

Chairman Enthoven began the discussion of this paper with an explanation about why he had chosen to make a change in the first recommendation before it was discussed by the Task Force. Dr. Enthoven stated that he altered the language after talking to members of the CalPERS board and getting their input. He felt the Task Force had a better chance of getting positive results from CalPERS with the new wording. He also explained that the recommended $500,000 was based on the amount of a Robert Wood Johnson Foundation grant.

Prior to discussion of the paper, Dr. Spurlock suggested the Task Force develop a mechanism to prioritize the recommendations once they are all passed. Mr. Zaremberg agreed and further suggested that staff create for the next meeting a matrix of each new government program or mandate under Task Force consideration.

Following there ensued a general discussion regarding risk adjustment. Comments from the members included:

- Mr. Zaremberg asked why CalPERS hadn't already adopted risk adjustment. Chairman Enthoven responded that the experts have only recently said that the methodology is good enough. He added that under the state's current health premium contribution method, risk adjusting premiums would lead to increased state costs. However, he stated that the state is currently considering adoption of a new contribution system that would make risk adjustment cost neutral.
- Mr. Williams stated that risk adjustment was a good objective, but he was concerned that it has been tested mostly on the Medicare population as opposed to the young population. He referred to an actuary report's conclusion that risk adjustment is untested and that any proposal should consider a modeling period.
- Mr. Kerr felt that risk adjustment was crucial to addressing incentives under capitation and that the system was sufficiently advanced to merit adoption now.
- Ms. Farber asked for a mechanism to assure that the larger risk adjusted premiums would actually go to providers and not be diverted to corporate profits.
- Ms. Finberg asked for more information about what is happening with risk adjustment in Medi-Cal and for descriptions of other risk adjustment models.
- Mr. Tirapelle stated that CalPERS is exploring risk adjustment based on age and gender rather than diagnoses. He also mentioned, and Chairman Enthoven confirmed, that risk adjustment

would have the effect of transferring some money from lower to higher income employees. Mr. Ramey disagreed with this statement.

- Mr. Ramey asked that the wording in the paper specify that risk adjustment be based on diagnosis or medical condition in addition to demographics.

Lunch Break - 12:10 PM -12:45 PM

Chairman Enthoven resumed the meeting by asking the members if there was enough interest in moving forward with the concept of recommending risk adjustment. Several members were concerned with the specific details and instead recommended creating a formal body or commission to devise a specific model for the state. Chairman Enthoven asked for public comment before a vote was taken.

Public Comment: -1:05 PM

1. **Judith Regeal**- California Medical Association. Ms. Regeal stressed the importance of risk adjusting payments to providers, not just plans.

2. **Nancy Welsh -**CalPERS. Ms. Welsh stated that CalPERS is very interested in risk adjustment but that their current plan does not include health status as a risk adjuster, largely due to confidentiality issues.

Mr. Tirapelle asked why CalPERS was chosen to implement risk adjustment. Dr. Enthoven responded that they have the centralized capability to handle implementation and also they are the largest cohesive purchasing entity. He pointed out that the recommendations request that CalPERS work with the University of California and the Pacific Business Group on Health to implement risk adjustment.

Proposed Recommendation No. 1

The Task Force strongly recommends to the CalPERS Board of Administration that CalPERS, preferably in combination with the University of California and PBGH, with its nearly three million members, take the lead in introducing risk adjustment to the California market. The Task Force recommends implementation of a state-of-the-art risk adjustment system within three years. The legislature should provide $500,000 for a study of how best to implement risk adjustment and ask CalPERS to report in two years, including its progress toward risk adjustment, the cost implications, any concerns about patient privacy, and a recommendation to proceed or not to proceed and why. The Task Force believes this would be in the best interests of California public employees, and would be a great public service to the people of California

Mr. Perez suggested that Recommendation No. 1 be amended so that it accurately reflected the discussion/agreement made by members at the October 10 meeting. Chairman Enthoven said that without objection, he would ensure such changes were made.

Ms. Farber moved to adopt Recommendation No. 1, as it is amended to reflect Mr. Perez's previous comment. Mr. Perez seconded the motion.

Mr. Kerr then moved to amend the recommendation to add "diagnosis based" language to it. Mr. Lee seconded this motion. The motion to amend Recommendation No. 1 was unanimously adopted, however, a vote on the main motion, as amended, failed with only 12 affirmative votes.

Mr. Perez then moved to adopt the Recommendation No. 1 [with the October 10 language] with one substitution: to change the word "direct" to "urge" so that the recommendation states "…that the Legislature urges CalPERS to…". Mr. Tirapelle seconded the motion. The Chairman then read the recommendation for the record[1]. The motion was adopted 17 to 0 in favor.

Proposed Recommendation No. 2

> *The legislature or Governor should instruct the California Department of Health Services (DHS) to seek to join with the Health Care Financing Administration (HCFA, administrator of the Medicare and Medicaid programs) in a cooperative project with beneficiaries to explore expanded efforts to do risk adjustment for payments to managed care plans serving Medi-Cal beneficiaries. The legislature or Governor should require DHS to report in two years, including its progress toward risk adjustment, the cost implications, any concerns about patient privacy, and a recommendation to proceed or not to proceed and why.*

Mr. Lee moved to adopt Recommendation No. 2 as proposed and Dr. Karpf seconded it. Mr. Zaremberg asked Ms. Belshe, as Director of the Department of Health Services, to comment on this recommendation before a vote is taken. Ms. Belsche indicated that from her perspective, the concept of Recommendation No. 2 merits further discussion, consideration and direction to the Department to engage in "that type of dialogue". She further indicated that as to the predictability of risk assessment to the medical population, the department is doing some adjusting. Those risk adjustments, according to Ms. Belshe, are based upon demographic characteristics.

After discussion by Task Force members on the issue of risk adjustment as it pertained to Recommendation No. 2, Mr. Lee moved to amendment the recommendation to add in the fourth line where it ends "…to do risk adjustments for services to medical beneficiaries…", to then strike "…payment to managed care plans serving…". Dr. Northway seconded the motion. The motion was adopted with 20 affirmative votes.

Proposed Recommendation No. 3

> *Similarly, the legislature or Governor should instruct DHS to participate in HCFA-sponsored risk adjustment demonstration projects for managed care plans serving Medicare beneficiaries as and when such demonstration projects are proposed.*

Mr. Perez moved that Recommendation No. 3 be adopted as proposed and Ms. Farber seconded it. Without discussion, the motion was adopted
19 to 0.

[1] Please see page 111 of the October 28, 1997 Task Force Meeting Transcript for exact language.

Proposed Recommendation No. 4

The legislature or Governor should direct DHS to explore with the federal Office of Personnel Management a California pilot project for risk adjustment of premiums for health plans serving federal employees in California in the Federal Employees Health Benefits Program (FEHBP).

Ms. Severoni moved that Recommendation No. 4 be adopted as proposed, and Mr. Kerr seconded it. Ms. Belshe questioned whether it is an appropriate means for the Department of Health Services to work in the direction given in Recommendation No. 4. Given that this would be a clarifying amendment, the Chairman ruled that without objection, an amendment would be made to the recommendation to read "…recommends the state explore with the Federal Office of Personnel Management the California pilot project for risk adjustment of premiums for health plans serving federal employees in California…". The motion to adopt the recommendation, as amended, was adopted with 20 affirmative votes.

Proposed Recommendation No. 5

Upon implementation by CalPERS of a risk adjustment mechanism, the legislature or Governor should consider requiring other new purchasing groups to risk adjust payments to participating plans within a reasonable timeframe after formation.

Mr. Perez moved to adopt recommendation No. 5 as proposed, and Dr. Spurlock seconded it. Mr. Zaremberg stated that he felt the Recommendation was premature. Although the Task Force will not be in existence when CalPERS completes the study urged in the Recommendation No. 1, he said that this recommendation should not be made until such a study is completed.

In response to Mr. Zarendberg's comments, Mr. Kerr suggested an amendment to read "…upon successful implementation by CalPERS in the risk adjustment system…" . Mr. Perez said that he felt the existing language added more flexibility. Mr. Kerr's suggestion was not placed in the form of a motion.

Mr. Williams moved to replace "direct" with "urge" where stated in Recommendation No. 4. Mr. Hauck seconded the motion. The motion failed with 3 affirmative votes.

Mr. Kerr then moved to amend the recommendation to replace "…other new…" with "all." Mr. Lee seconded the motion which was adopted with 17 affirmative votes.

Mr. Lee then moved to amend the recommendation to add "upon receipt of reports recommended from CalPERS and DHS". Mr. Lee's motion was not seconded.

Chairman Enthoven then called to question on the main motion as amended. The motion was adopted with 17 affirmative votes.

Break - 3:30 Pm

Proposed Recommendation No. 6

> *Major purchasers doing risk adjustment should require as a matter of contract, and as soon as technically feasible but no later than the year 2000, the state should require as a matter of licensure, that health plans pass through risk adjustment to their contracting providers or use some other mechanism that appropriately compensates for risk (e.g., stop loss coverage, carve outs, global case rates.*

Dr. Karpf suggested that "or" be replaced with "and" or to stop the sentence after "…providers….". Chairman Enthoven suggested that in place of Dr. Karpf suggestion, the sentence "In addition to other mechanisms that appropriately compensate for risk" be added to the recommendation. Dr. Karpf indicated this addressed his concerns.

Ms. Farber then moved to adopt Recommendation No. 6 as revised, and Mr. Perez seconded it. Chairman Enthoven stated that without objection, he would delete "…no later than the year 2000…" from the recommendation. No objection was raised.

After much discussion, Mr. Kerr moved to amend the recommendation to make it applicable to "treating providers". Ms. Farber seconded the motion. The amendment was adopted with 19 affirmative votes.

Dr. Conom then moved to delete the words "…pass through" and just say "risk adjusted payments to treating providers". Dr. Karpf seconded the motion to amend. The motion to amend failed with 8 affirmative votes.

Break

Chairman Enthoven moved to replace Recommendation No. 6 with the following language:

> As soon as technically feasible, the state should require as a matter of licensure, that health plans risk adjust payments to their contracting treating providers in addition to using other mechanisms that appropriately compensate for risk, [e.g., stop/loss coverage, carve outs, global base rates]. When premiums are risk adjusted so that those risk adjustments flow through to treating providers as well.

Mr. Kerr seconded the motion was adopted with 18 affirmative votes.

Proposed Recommendation No. 7

> *Major purchasers, including the state, and foundations should make moving forward the science of risk adjustment (and the ability to monitor its impact on clinical outcomes for vulnerable populations) a high priority through funding and support.*

Mr. Lee suggested that the word "should" be replaced with "are strongly encouraged to" as indicated in Recommendation No. 7. Dr. Spurlock also suggested replacing "vulnerable populations" to "different populations". Chairman Enthoven asked if there was objection to these replacements. Seeing and hearing none, he declared the Recommendation revised to incorporate Mr. Lee and Dr. Spurlok's suggestions.

Mr. Lee then moved to adopt Recommendation No. 7 as amended. Mr. Kerr seconded it and the motion was adopted with 20 affirmative votes.

New Recommendation No. 8

Dr. Romero read into the record the following newly proposed recommendation:

> *A state regulatory organization such as the Department of Corporations or a new office of State Health System Oversight if created, should be charged with facilitating these [recommendations 1 through 7] efforts and reporting the progress annually to the Governor and the Legislature.*

Mr. Rodgers moved to adopt Dr. Romero's language and Ms. Farber seconded it. Chairman Enthoven then moved to replace "…a state regulatory organization such as the Department of Corporations or a new office of State Health System Oversight if created should be charged with facilitating …" with "the lead state agency responsible for managed care oversight should be charged for overseeing …". Mr. Perez seconded the motion and it was adopted with 19 affirmative votes.

Executive Summary

Mr. Perez moved to adopt the Executive Summary, as amended to reflect the newly adopted recommendations. Ms. Severoni seconded the motion.

Ms. Belshe, Mr. Zatkin and Mr. Zaremberg all expressed concerns about voting to give responsibility to an agency or new office without first identifying all the problems. Mr. Zaremberg also wanted some clarification about the term "skimming". He and Mr. Williams both felt that the paper focuses largely on adverse selection as a problem in the marketplace. They were trying to understand what the true intent of the paper really is. Whether it is appropriate to avoid and accept risk and to market to the healthy populations. Chairman Enthoven stated that the intent of the paper is not to stigmatize people but to develop a system that requires or causes people to pool risk broadly. He thinks that the system that allows people who are healthy to escape contributing to the cost of the sick is a defective system.

Mr. Williams then moved to amend the Executive Summary to read "some leading experts believe that good enough methods are now available and already put into practice." Mr. Hauck seconded the motion and it failed with 14 affirmative votes.

The Executive Summary was adopted with 17 affirmative votes.

Public Comment:

Steve Thomson -California Medical Association. Mr. Thomson felt it was entirely appropriate to use the word "skimming" in the report.

Break

C. Discussion of the Balancing Private and Public Sector Roles Paper - 4:00 PM

This paper was for discussion only with no votes taken. Chairman Enthoven briefly summarized the paper's contents, explaining that it was written as a response to the Governor's request for the Task Force to advise on the appropriate role of government and how that role should be carried out. He asked the Task Force members for their opinions as to whether this paper was worth

pursuing. Many members felt that the paper should be abandoned. Others liked the material and suggested that sections of it be used in other papers. A few members felt the paper was premature and should be tabled until a later date. Chairman Enthoven agreed to abandon the paper and have staff move portions of it to other papers.

D. Discussion of the Standardization of Benefits paper - 4:18 PM

Task Force members discussed requiring plans, government or a non-profit group to compare each plan's benefits to one of several established benchmark benefit packages, rather than mandating that certain standardized packages be used. Ms. Finberg advocated requiring the plans, if they offer any packages at all, to offer one or more of the standardized packages. Mr. Shapiro suggested that an appropriate role for government might include screening the comparisons the health plans make or consolidating the information to produce one comprehensive comparison. Dr. Spurlock made an analogy to the rules government establishes regarding food labels.

Public Comment: 4:40 PM

Carol Lee - California Medical Association. Ms. Lee stated that in general the CMA felt that this paper was very positive. She suggested that the paper include a recommendation for stakeholders to devise a comprehensive, standardized Evidence of Coverage disclosure form. She suggested that the disclosure be publicly available so that various groups could have the data to compare plans.

Mr. Shapiro suggested that the Task Force consider standardizing the disclosures. Ms. Belshé stated that Medi-Cal uses standardized disclosure forms to some extent. Mr. Tirapelle stated that CalPERS does also.

Break - 5:00 Pm

VI. NEW BUSINESS - 5:15 PM

A. Discussion of the Expanding Consumer Choice Paper

Chairman Enthoven opened the floor to Mr. Zaremberg for discussion of this paper. Mr. Zaremberg stated that the purpose of the paper is to encourage more utilization of purchasing pools in order to increase consumer choice of plans and physicians. The difficulty is how to go about promoting this concept. Mr. Zaremberg outlined several topics from the paper that he was not certain that he supported, including whether agents should be allowed to be sponsors of purchasing pools; requiring employers to offer choices to their employees; and eliminating plan participation rate requirements. After Mr. Zaremberg's summary, Chairman Enthoven invited Task Force members to comment on the paper.

Mr. Williams stated that elimination of plan participation requirements would be the death of PPOs due to adverse selection. Chairman Enthoven stated that the rule should be applied only when the employer is trying to offer similar products. Mr. Zatkin suggested that it might be simpler to limit participation requirements to 50%, allowing for dual choice.

Mr. Werdegar asked why so many small employers go through a broker rather than the Health Insurance Plan of California (HIPC). Chairman Enthoven thought the HIPC might not have

sufficient marketing resources. Mr. Zaremberg thought it might be due to the fact that originally the HIPC did not pay a commission to brokers and agents.

Mr. Shapiro stated that he would be developing proposals to expand purchasing pools in the individual and mid-size (51-100 employees) group market, either by expanding the HIPC or creating new purchasing pools. Mr. Zaremberg stated that he did not support expanding the HIPC to the mid-size market because that market does not have the same access problems that the small group market did and the expansion would lead to fewer PPOs.

Dr. Karpf asked if the Task Force was also going to discuss access, in terms of people having an exit strategy when they are uncomfortable with access in their plan. Chairman Enthoven said that the best strategy is to have choice so the plan knows their members can leave. Dr. Alpert stated that maybe the Task Force should consider building in a POS option. Chairman Enthoven said that that strategy had been tried in Maryland but was problematic under the Employee Retirement Income Security Act (ERISA), which prevents the states from mandating any kind of employee benefit. Dr. Northway asked for clarification as to whether the members were suggesting the POS option be available at the annual open enrollment period or at the time that the individual gets sick. Dr. Spurlock stated that POS products tend to rate lowest in terms of patient satisfaction. Ms. O'Sullivan suggested that to avoid ERISA, the Task Force could mandate that all plans have a POS option, similar to state mandates that specific services be covered. Chairman Enthoven believed that would still be a problem under ERISA.

Mr. Lee requested either that this paper be retitled to acknowledge that it does not address individual choice or that it be revised to include options for the individual market. He also felt that the issue of choice of providers was not addressed, only choice of plan.

Returning to the POS topic, Mr. Shapiro stated that the mandate proposed by Ms. O'Sullivan would actually lead to decreased choice. Mr. Romero suggested an alternative that would mandate that if a carrier offers plans, one of those offerings must be a POS plan. Mr. Zatkin responded that not all carriers are in a position to offer POS. Ms. Skubik stated that a POS can be structured in such a way that it is the same price as an HMO. Chairman Enthoven stated that it could even be structured in a way that the plan saves money when the patient goes out of the network.

Mr. Kerr urged Task Force members to think "outside the box." He suggested a new recommendation that if an employer offers only one choice, the individual should automatically have access to a purchasing pool, regardless of the size of the employer. Mr. Zatkin questioned where the money for this proposal would come from, given that the state can't force the employer to contribute to the purchasing pool.

Public Comment: - 5:55 Pm

1. **Catherine Dodd -** American Nurses Association of California. Ms. Dodd requested that the Task Force adopt a recommendation stating that provider panels need to reflect all the people who are providing care for the patient, not just physicians. She stated that other states and the President's Commission have already adopted this proposal. She also asked that regulatory barriers that keep nurse practitioners from providing care within their scope of practice be eliminated.

2. **Judy Gould -** California Dietetic Association. Ms. Gould stated that she agreed with the comments from Ms. Dodd but that she was concerned with the use of the term "licensed". She suggested using the term "appropriately credentialed" instead because some health

professionals, such as registered dieticians and occupational therapists, are not licensed. She also spoke about the issue of consumers being harmed under the managed care system because they cannot get the referrals to dietary programs that they need. She stated that consumers need access to accurate information and scientific, valid nutritional treatments.

3. **Edward Doletsji -** California Catholic Coalition. Mr. Doletsji suggested that the Task Force come to a common understanding about the nature of health care in the state by clarifying whether it is a personal right, a public good, a private commodity, etc.

VIII. ADJOURNMENT - 6:15 PM

Chairman Enthoven declared that without any objection, the business meeting would be adjourned. Seeing no objection, Chairman Enthoven adjourned the meeting.

Prepared by: Ms. Stephanie Kauss